

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037028</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Villa Health Care East</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>100 Marian Parkway, PO Box 109</u> <u>Sherman</u> <u>62684</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Sangamon</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Chad Butterfield, THCSLLC, Mgt. Co. for</u>	
Telephone Number: <u>(217) 744-2299</u> <u>Fax #</u> _____		(Title) <u>Villa Health Care East</u>	
IDPA ID Number: <u>37-1215144</u>		(Signed) _____ (Date) _____	
Date of Initial License for Current Owners: _____		Paid Preparer (Print Name and Title) <u>Olive LLP</u>	
Type of Ownership:		(Firm Name & Address) <u>205 S. 5th Street, Suite 645, Springfield, IL 62701</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Telephone) <u>(217) 753-1375</u> <u>Fax # (217) 744-0193</u>	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steven D. Tenhouse, Olive LLP</u> Telephone Number: <u>(217) 753-1375</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Health Care East# 0037028 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,234</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,829</u>	<u>0</u>	<u>1,133</u>	<u>2,962</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>9,595</u>	<u>21,415</u>	<u>10</u>	<u>31,020</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>11,424</u>	<u>21,415</u>	<u>1,143</u>	<u>33,982</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.78%

D. How many bed-hold days during this year were paid by Public Aid?

86 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/21/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/21/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 10 and days of care provided 1,133Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/00

Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	159,365	10,044	7,659	177,068		177,068	(6)	177,062		1
2	Food Purchase		138,801		138,801		138,801	(597)	138,204		2
3	Housekeeping	92,416	19,500		111,916		111,916		111,916		3
4	Laundry	43,155	14,207	10	57,372		57,372	(6,488)	50,885		4
5	Heat and Other Utilities			102,611	102,611		102,611		102,611		5
6	Maintenance	22,463	10,407	74,256	107,126		107,126		107,126		6
7	Other (specify):*			6,169	6,169		6,169		6,169		7
8	TOTAL General Services	317,399	192,959	190,705	701,063		701,063	(7,091)	693,973		8
	B. Health Care and Programs										
9	Medical Director			16,250	16,250		16,250		16,250		9
10	Nursing and Medical Records	1,270,283	97,285	5,450	1,373,018		1,373,018		1,373,018		10
10a	Therapy										10a
11	Activities	51,941	14,017	5,633	71,591		71,591		71,591		11
12	Social Services	85,713	350	3,472	89,535		89,535		89,535		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,407,937	111,652	30,805	1,550,394		1,550,394		1,550,394		16
	C. General Administration										
17	Administrative	61,752			61,752		61,752		61,752		17
18	Directors Fees										18
19	Professional Services			221,059	221,059		221,059		221,059		19
20	Dues, Fees, Subscriptions & Promotions			65,069	65,069		65,069	(33,596)	31,473		20
21	Clerical & General Office Expenses	64,133	34,608	203,283	302,024		302,024	(176,480)	125,544		21
22	Employee Benefits & Payroll Taxes			265,400	265,400		265,400		265,400		22
23	Inservice Training & Education			617	617		617		617		23
24	Travel and Seminar			7,639	7,639		7,639		7,639		24
25	Other Admin. Staff Transportation			5,642	5,642		5,642		5,642		25
26	Insurance-Prop.Liab.Malpractice			56,134	56,134		56,134		56,134		26
27	Other (specify):*										27
28	TOTAL General Administration	125,885	34,608	824,843	985,336		985,336	(210,076)	775,260		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,851,221	339,219	1,046,353	3,236,793		3,236,793	(217,166)	3,019,627		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Villa Health Care East

#0037028

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			158,738	158,738		158,738	(14)	158,724			30
31	Amortization of Pre-Op. & Org.			4,291	4,291		4,291	(4,291)	0			31
32	Interest			299,491	299,491		299,491	(1,493)	297,998			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			2,875	2,875		2,875		2,875			34
35	Rent-Equipment & Vehicles			350	350		350		350			35
36	Other (specify):*											36
37	TOTAL Ownership			465,745	465,745		465,745	(5,798)	459,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,679	66,766	124,445		124,445	(10,202)	114,243			39
40	Barber and Beauty Shops			22,257	22,257		22,257	(20,340)	1,917			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,081	54,081		54,081		54,081			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		57,679	143,104	200,783		200,783	(30,542)	170,241			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,851,221	396,898	1,655,202	3,903,321		3,903,321	(253,506)	3,649,815			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(6)	1		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space		34		6
7 Sale of Supplies to Non-Patients	(10,202)	39		7
8 Laundry for Non-Patients	(6,488)	4		8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(1,493)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax		32		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)		25		16
17 Non-Care Related Fees				17
18 Fines and Penalties	(1,043)	21		18
19 Entertainment				19
20 Contributions		20		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(16,452)	21		24
25 Fund Raising, Advertising and Promotional	(33,596)	20		25
Income Taxes and Illinois Personal				
Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(179,936)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (249,216)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
Amortization of Organization &			
33 Pre-Operating Expense	(4,291)	31	33
Adjustments for Related Organization			
34 Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (4,291)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (253,506)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0037028
Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Vendor Income	\$ 0	1
2	Barber and Beauty Revenue	(29,340)	2
3	Extraordinary Income/(Expense)		3
4	(Gain)/Loss on Sale of Assets	0	4
5	Miscellaneous (Income)/Expense	(409)	5
6	Adjust Depreciation Expense to Schedule X1	(14)	6
7	Raw foods rebate	(597)	7
8	Lobbying portion of IHCA dues	(909)	8
9	Miscellaneous Expense	(121,221)	9
10	Home Office Allocation	(26,446)	10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(179,936)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(6)	0	0	0	0	0	0	0	0	0	0	(6)	1
2	Food Purchase	(597)	0	0	0	0	0	0	0	0	0	0	(597)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(6,488)	0	0	0	0	0	0	0	0	0	0	(6,488)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,091)	0	0	0	0	0	0	0	0	0	0	(7,091)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(33,596)	0	0	0	0	0	0	0	0	0	0	(33,596)	20
21	Clerical & General Office Expenses	(176,480)	0	0	0	0	0	0	0	0	0	0	(176,480)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(210,076)	0	0	0	0	0	0	0	0	0	0	(210,076)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(217,166)	0	0	0	0	0	0	0	0	0	0	(217,166)	29

Summary B

12/31/00

[illegible]

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Health Care East# 0037028Report Period Beginning: 01/01/00Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Health Care East# 0037028

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC		X	Mortgage	Varies	11/1/99	\$ 4,357,417	\$ 4,357,417	11/1/29	6.50%	\$ 297,398	1	
2	GE Capital notes		X	Van	\$958.00	12/1/98	38,880	10,987	12/1/02	8.50%	2,093	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Interest Income		X								(1,493)	6	
7	H/O Interest Income	X										7	
8												8	
9	TOTAL Facility Related				\$958.00		\$ 4,396,297	\$ 4,368,404			\$ 297,998	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,396,297	\$ 4,368,404			\$ 297,998	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Villa Health Care East**# **0037028** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet: 38,368
 B. General Construction Type:

Exterior Brick and Block
 Frame _____

 Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
 If so, please complete the following:

1. Total Amount Incurred: 218,190

2. Number of Years Over Which it is Being Amortized: Various

3. Current Period Amortization: 4,291

4. Dates Incurred: Various

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>			\$ <u>465,019</u>	1
2					2
3	TOTALS			\$ <u>465,019</u>	3

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991	1991	\$ 2,837,150	\$ 94,572	30	\$ 94,572	\$ 0	\$ 874,789	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements - 1991			91	1,316	132	10	132		1,218	9
10	Improvements - 1992			92	31,351	1,071	29	1,081	10	9,347	10
11	Improvements - 1993			93	16,743	708	29	577	(131)	5,352	11
12	Improvements - 1994			94	13,516	647	29	466	(181)	4,237	12
13	Improvements - 1995			95	56,538	4,519	18	3,141	(1,378)	20,673	13
14	Improvements - 1996			96	17,671	1,160	15	1,178	18	5,758	14
15	Exhaust fan			97	1,495	100	15	100	(0)	390	15
16	Land Surveyor - John Reynolds			97	11,823	1,182	10	1,182	(0)	4,267	16
17	Carpet			97	20,270	2,027	10	2,027		6,757	17
18	VRA ponds and signs			97	1,613	161	10	161	(0)	497	18
19	Carpet - 13 rooms			98	9,713	1,943	5	1,943	(0)	4,047	19
20	Panic Bar - 4			98	2,205	147	15	147	0	306	20
21	Mats - Doorway			98	1,114	111	10	111		232	21
22	Door hand swing			98	494	33	15	33	0	80	22
23	Wallpaper			98	8,480	848	10	848	0	2,544	23
24	Carpet - 13 rooms			98	6,470	1,294	5	1,294		2,804	24
25	Culvert			98	31,107	1,728	18	1,728		4,176	25
26	Driveway sealer			98	3,547	296	12	296	0	640	26
27	Culvert			98	5,103	284	18	284		780	27
28	Water Heater-80 gal			98	3,820	255	15	255	(0)	658	28
29	Privacy curtains			98	2,689	538	5	538	(0)	1,345	29
30	Carpeting/blinds			99	9,684	1,937	5	1,937	(0)	3,874	30
31	Paint			99	2,733	547	5	547	(0)	1,093	31
32	Alz unit			99	3,623	242	15	242	(0)	483	32
33	Landscape			99	2,500	250	10	250		479	33
34	Drainage			99	3,010	201	15	201	(0)	334	34
35	Carpet			99	6,470	431	15	431	0	863	35
36	TOTAL (lines 4 thru 35)				\$ 3,112,247	\$ 117,362		\$ 115,700	\$ (1,663)	\$ 958,023	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Tile work		99	26,831	1,789	15	1,789	0	2,236	9
10		Exterior lighting		99	1,868	125	15	125	0	156	10
11		Thermometer		99	1,058	106	10	106	0	115	11
12		Door replacement		99	1,270	85	15	85	(0)	99	12
13		Firewall		99	16,693	835	20	835	0	835	13
14		Culverts		99	2,025	113	18	113		225	14
15		Fire doors		99	3,680	245	15	245	0	368	15
16		Blinds		99	916	92	10	92		176	16
17		Damper-Fire/Smoke		99	2,455	164	15	164	(0)	191	17
18		Culverts		2000	50,860	1,415	18	2,826	1,410	1,415	18
19		Heat Exchanger		2000	1,500	8	15	100	92	8	19
20		Emergency circuits		2000	7,662	383	20	383		383	20
21		Firewall repair		2000	5,010	180	25	200	21	180	21
22		Firewall reinforcement		2000	18,309	598	25	732	134	598	22
23		Heat/Cool Zoneline		2000	1,435	60	10	143	84	60	23
24		Timer system		2000	495	8	15	33	25	8	24
25		Door Access System		2000	1,337	15	15	89	74	15	25
26		Braille signs		2000	4,867	34	12	406	372	34	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 148,272	\$ 6,253		\$ 8,464	\$ 2,212	\$ 7,101	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 525,517	\$ 20,712	\$ 20,712			\$ 433,847	37
38	Current Year Purchases	25,269	1,556	1,556		10	1,556	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 550,786	\$ 22,268	\$ 22,268			\$ 435,403	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42		95 Ford Taurus	1995	\$ 18,261	\$ 1,826	\$ 3,652	\$ 1,826	5	\$ 18,261	42
43		98 Aerotech 220 Bus	1998	43,200	8,640	8,640		5	21,600	43
44										44
45										45
46	TOTALS			\$ 61,461	\$ 10,466	\$ 12,292	\$ 1,826		\$ 39,861	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,337,784	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 156,349	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 158,724	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 2,375	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,440,388	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	WIP	\$ 171,634	58
59			59
60			60
61		\$ 171,634	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 350 Description: See attached detail

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	742	\$ 15,073	\$ 0	742	\$ 15,073	1
2	Licensed Speech and Language Development Therapist		hrs		139	3,451	0	139	3,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,043	34,086	0	2,043	34,086	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	2,924	\$ 52,609	\$	2,924	\$ 52,609	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Villa Health Care East

0037028

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 55,136	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	375,310		3
4	Supply Inventory (priced at)	18,977		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	39,368		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 488,791	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	572,160		13
14	Buildings, at Historical Cost	3,130,812		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	806,445		16
17	Accumulated Depreciation (book methods)	(1,444,850)		17
18	Deferred Charges	218,190		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	233,483		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,516,241	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,005,032	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 173,966	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	384		29
30	Accrued Salaries Payable	124,937		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other liab.'s and Patient Trust Dep	137,488		36
37	Due to affiliates	27,837		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 464,612	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,357,417		39
40	Mortgage Payable	10,987		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,368,404	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,833,016	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (827,984)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,005,032	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (490,106)	1
2	Restatements (describe):		2
3	Prior Year Audit Adjustments	(65,947)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (556,053)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(271,931)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (271,931)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (827,984)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,089,485	1
2	Discounts and Allowances for all Levels	(754,142)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,335,343	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,688	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 252,688	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	20,340	13
14	Non-Patient Meals	6	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	10,202	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	6,488	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 37,036	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,493	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,493	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Extraordinary Income/Loss & Misc.	4,830	28
28a	G/L on Sale of Asset		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,830	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,631,390	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	701,063	31
32	Health Care	1,550,394	32
33	General Administration	985,336	33
	B. Capital Expense		
34	Ownership	465,745	34
	C. Ancillary Expense		
35	Special Cost Centers	146,702	35
36	Provider Participation Fee	54,081	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,903,321	40
41	Income before Income Taxes (line 30 minus line 40)**	(271,931)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (271,931)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Villa Health Care East# 0037028Report Period Beginning: 01/01/00Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	8,538	9,115	\$ 171,028	\$ 18.76	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	5,360	5,689	103,798	18.25	3
4	Licensed Practical Nurses	23,983	25,456	360,277	14.15	4
5	Nurse Aides & Orderlies	65,300	69,337	615,231	8.87	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	5,283	5,579	51,941	9.31	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	6,416	6,827	85,713	12.55	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	18,679	19,621	159,365	8.12	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,173	2,297	22,463	9.78	17
18	Housekeepers	11,645	12,219	92,416	7.56	18
19	Laundry	6,314	6,594	43,155	6.54	19
20	Administrator	2,322	2,160	61,752	28.59	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	7,394	6,879	64,133	9.32	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	2,254	2,097	19,950	9.51	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,661	173,870	\$ 1,851,220 *	\$ 10.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	189	\$ 7,659	line 1, col 3	35
36	Medical Director	52	16,250	line 9, col 3	36
37	Medical Records Consultant	42	1,250	line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	128	9,565	line 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	914	line 11, col 3	44
45	Social Service Consultant	17	913	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	445	\$ 36,551		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	Ln 10, Col 1	50
51	Licensed Practical Nurses		0	Ln 10, Col 1	51
52	Nurse Aides		0	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Cindy Schaaf	Administrator		\$ 61,752	Workers' Compensation Insurance		\$ 57,209	IDPH License Fee		\$ 186
				Unemployment Compensation Insurance		35,042	Advertising: Employee Recruitment		23,511
				FICA Taxes		114,776	Health Care Worker Background Check (Indicate # of checks performed 33)		2,040
				Employee Health Insurance		50,509			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		5,736
				Other Benefits		7,866	Advertising PR & Other		33,596
				Home Office Allocation		0			
							Reclassifications		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Less: Public Relations Expense		()
B. Administrative - Other							Non-allowable advertising		(33,596)
							Yellow page advertising		()
Description				Amount					
				\$			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 31,473
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$					
C. Professional Services							G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description		Line #	Description		Amount
Various	Purch Serv		\$ 20,310				Out-of-State Travel		\$
Tutera Health Care Mgt	Management Fees		164,005						
Various	Legal Fees		6,543						
Various	Accounting Fees		9,915				In-State Travel		7,639
Various	D/P Fees		16,837				Home Office Allocation		0
Various	Professional Serv		3,450						
Various	Trustee Expenses		0						
							Seminar Expense		
							Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 7,639
							TOTAL		\$

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Health Care East

STATE OF ILLINOIS

0037028

Report Period Beginning: 01/01/00

Ending: 12/31/00

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? N
- (2) Are there any dues to nursing home associations included on the cost report? Y
If YES, give association name and amount. IHCA, 3923
- (3) Did the nursing home make political contributions or payments to a political action organization? N If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Y
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES N NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,081
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? N If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Y Indicate the amount. \$ 6
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? N
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Y
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Y
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Y
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N
Firm Name: BKD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. In progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Y
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Y
Attach invoices and a summary of services for all architect and appraisal fees.